

## EXTRACT FROM THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR THE YEAR 1955\*

### VENEREAL DISEASES

*Syphilis*.—For the first time since 1947 the number of new patients attending the clinics with infections of less than one year has failed to fall and in 1955, 609 male and 228 female cases were reported as against 600 male and 208 female in 1954. The significance of this slight rise is not certain, but it will be seen that new infections in both sexes have appreciably increased in London and in the Port of Liverpool. It must also be remembered that many immigrants from territories where the prevalence of syphilis is still high continue to arrive in the country and during the last year a few instances of importation of infection have been noted.

EARLY SYPHILITIC INFECTIONS DEALT WITH FOR THE FIRST TIME IN 1954 AND 1955 IN TEN SAMPLE AREAS

Urban Area	1954			1955		
	Males	Fe-males	Total	Males	Fe-males	Total
London Administrative Area (3,295,000)*	190	44	234	205	67	272
Merseyside (Liverpool, Bootle, Birkenhead, Wallasey) (1,102,250)	50	6	56	80	16	96
Manchester and Salford (861,500)	24	12	36	20	12	32
Tyneside (Newcastle, South Shields and Tynemouth) (455,900)	12	5	17	10	4	14
Hull (299,600)	8	4	12	8	1	9
Southampton (194,900)	14	1	15	13	1	14
Bristol (442,500)	25	1	26	17	1	18
Birmingham (1,111,700)	14	6	20	12	5	17
Leeds and Bradford (793,800)	13	8	21	15	10	25
Sheffield (501,100)	8	2	10	3	1	4

\* The figures in brackets are the estimated populations at June 30, 1955.

Rather fewer patients with late or latent syphilis were registered at the clinics in 1955 (3,502 as against 3,787 in 1954). These are classified below.

Condition	Year	Males	Females	Total
Cardiovascular syphilis ..	1954	355	140	495
	1955	311	113	424
Neurosyphilis ..	1954	501	279	780
	1955	419	262	681
All other late or latent stages	1954	1,220	1,292	2,512
	1955	1,162	1,235	2,397
Total late or latent syphilis	1954	2,076	1,711	3,787
	1955	1,892	1,610	3,502

\* Part II of the Report of the Ministry of Health for the year ended December 31, 1955. Cmnd. 16, p. 64 and Appendix C., p. 254.

It is probable that many cases of cardiovascular syphilis do not reach the clinics and consequently escape anti-syphilitic treatment. This is regrettable as, though "cure" of the condition after it has become symptomatic is rarely, if ever, possible, studies of treated and non-treated patients suggest that in many cases this specific treatment can play an important part in helping to prolong life.

Not a few immigrants from the tropics attending the clinics with other conditions show positive or weakly positive serum tests and it is sometimes uncertain whether these are caused by syphilis or yaws. Careful clinical and historical investigation is necessary in all these patients and it is fortunate that the treatment of both diseases is substantially the same.

With the decrease in the prevalence of symptomatic syphilis and the extension of routine blood testing, the correct diagnosis of latent infection has become increasingly important and the problem of the individual with doubtful or anomalous serum reactions seems to arise more often than formerly. The treponemal immobilization (TPI) test is of great help in difficult cases and it is hoped that this rather complicated but very useful test will become more available to venereologists in the future. It must be remembered, however, that the test gives positive results in all treponemal diseases and will not distinguish between syphilis and yaws.

Table E of the Appendix gives the Registrar General's figures of deaths from general paralysis of the insane, tabes dorsalis and aneurysm of the aorta. The fact that deaths from aortic aneurysm have increased in both sexes is some indication of the continuing prevalence of cardiovascular syphilis in the community.

The numbers of new cases of infantile congenital syphilis (under one year) has fallen slightly from 48 in 1954 to 41 in 1955 and fewer cases among older children and adults were diagnosed. (See Appendix, Table C.) It is reassuring to know that for the first year on record there were no deaths due to congenital syphilis in infants under one year.

*Syphilis Testing in Pregnancy*.—Results of serological tests for syphilis on blood from pregnant women have again been given by six regional blood transfusion centres and are shown in the Table opposite.

## CASES OF SYPHILIS (ANTE-NATAL), 1955

Regional Blood Transfusion Centre	No. of Ante-natal Patients Tested			Positive Syphilis Tests				
	Primiparae	Multiparae	Parity not known	Primiparae		Multiparae		Parity not known
				No.	Per cent.	No.	Per cent.	
Leeds .. .. .	7,355	8,275	5,727	23	0·31	29	0·35	17
Sheffield .. .. .	11,151	8,134	—	12	0·11	31	0·38	—
Liverpool .. .. .	18,017	16,177	—	36	0·20	77	0·48	—
Plymouth (sub-centre) .. .. .	1,842	1,736	—	8	0·43	8	0·46	36
Oxford .. .. .	1,287	1,638	217	1	0·08	4	0·24	—
Cambridge .. .. .	1,740	4,752	5,272	5	0·29	25	0·53	11
Total .. .. .	41,392	40,712	11,216	85	0·21	174	0·43	64

From the Leeds centre the returns showed 3,408 "old cases" tested as well as "new cases" shown in the table; of these, eight were primiparae, 3,078 multiparae and 322 in which parity was not known. Eight positive results were obtained in the group of multiparae, i.e., 0·26 per cent. In addition 11,590 specimens were tested at the South London Centre; nine positive results were found in primiparae and three positive results in multiparae.

Summary of results for the past four years is shown below:

Year	No. of Primiparae	Percentage Positive	No. of Multiparae	Percentage Positive
1952	6,331	0·25	5,955	0·60
1953	28,263	0·21	27,573	0·43
1954	39,181	0·23	47,941	0·32
1955	41,392	0·21	40,712	0·43

*Gonorrhoea.*—In 1955 the clinic incidence of gonorrhoea in both sexes increased and it is now clear that there has been no appreciable improvement in the control of this disease during the last five years. Although gonorrhoea is not at present the major medical problem that it was in pre-penicillin days, there are some indications that the results of treatment may not be so good as they were, and relapses needing re-treatment, though still unusual, are less uncommon than they used to be. So far, however, strain-resistance to penicillin has not been proved, but the situation needs to be watched carefully.

*Other Venereal Diseases.*—The number of new cases of chancroid was virtually unchanged in 1955 (see Appendix, Table A) but there has been an appreciable increase in lymphogranuloma venereum from 63 cases in 1954 to 86 in 1955. This virus disease is usually encountered amongst immigrants from tropical and subtropical areas where its prevalence is comparatively high. It is, however, not necessarily a tropical disease and in the past, outbreaks have occurred in temperate climates, usually in seaports. Untreated, as it too often is in the female, it is a cause of progressive ill-health, stricture

of the rectum being a not uncommon complication. Nine cases of the rare tropical venereal condition granuloma inguinale (Donovan) were also recorded and it is of interest that seven of these were reported from Birmingham. In the past the very few diagnosed cases invariably occurred amongst visiting seamen.

New cases of non-gonococcal urethritis in males again rose from 13,279 in 1954 to 14,269 in 1955 and are now slightly more numerous than those of gonorrhoea. Research is proceeding into the cause and cure of this disease though the aetiology of most of the cases is still obscure. It is important that as many female contacts as possible be tactfully traced, carefully investigated, and treated, if any impact is to be made on the increasing frequency of this condition. The great majority of cases appear to be venereal in origin and it seems right to regard the condition as yet another venereal disease.

*Other Conditions dealt with at Clinics.*—Many patients with various other conditions requiring treatment and even more needing reassurance only (in all 57,306), continue to attend the clinics. The investigation and instruction of these patients, time-consuming though it may be, is an important part of the work of the venereologist.

*The Present Position.*—Though more new cases of gonorrhoea and non-gonococcal urethritis attended the clinics in 1955 than in the previous year, there is some evidence to suggest that this may reflect a higher reinfection rate rather than a true increase in prevalence. It must also be recorded that since June, 1955, Royal Air Force personnel have been referred to the civilian clinics for investigation and treatment and these cases are included in their returns. The number of these patients, mostly cases of non-gonococcal urethritis, is, however, so small as to make little impression on the total clinic figures.

Though it is not known how many patients are treated elsewhere than at the clinics, it is of interest that no less than 313 cases of syphilis (87 male and 226 female) and 436 of gonorrhoea (162 male and

274 female) were treated in H.M. prisons during 1955. Of the syphilitic infections no less than 28 men and 72 women were in the early infectious stages of the disease. At Holloway Women's Prison 48 cases of syphilis (ten in the early infectious stages), 148 of gonorrhoea, and no less than 407 cases of other genital conditions were treated during the year. It is more than likely that many in the last named category were sources of infection of non-gonococcal urethritis in men if not of gonorrhoea.

Among 216 known prostitutes examined in Holloway during 1955, thirty cases of syphilis and 73 of proved gonorrhoea were discovered, but the visiting venereologist considers that "many of the non-venereal discharges were very suspicious of gonorrhoea". It is revealing that of the 216 examined, 47 were under 21 and many admitted sexual promiscuity from the age of 14 years. In great cities, especially in London, the prostitute is inevitably responsible for the spread of much infection. In whatever manner this age-old problem is to be tackled, one thing is certain, that the doors

of the clinics must be kept wide open for her and, once a patient, she must be treated with particular kindness and consideration if any impression at all is to be made on her social as well as her physical sickness.

It cannot be repeated too often that the control of venereal disease depends largely on successful contact tracing. Though the original patient is usually the most effective agent for this purpose, cases often arise where this is not so. Here the services of an experienced worker can be invaluable and, generally speaking, the trained health visitor on the staff of the Medical Officer of Health has the right background for this often delicate task. Speed, however, is the essence of success in nearly every case and it is important that whoever undertakes this work should be in close and constant contact with patients as well as clinicians. Though local circumstances will govern how this is to be arranged, a close liaison between Medical Officer of Health and Venereologist is necessary if an effective procedure is to be evolved and put into practice.

## APPENDIX

TABLE A  
NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE\*

Sex	Year	Syphilis	Soft Chancre	Gonorrhoea	Non-Gonococcal Urethritis (males only)	Other Conditions†		Total Attendances
Males	1939	7,273	827	24,811	—	24,324		1,587,111
	1940	7,093	887	21,057	—	20,005		1,170,412
	1941	7,790	1,017	20,572	—	20,476		1,065,114
	1942	8,529	969	17,956	—	22,302		1,071,664
	1943	8,790	773	18,215	—	36,868		1,082,427
	1944	7,667	628	16,629	—	34,123		973,810
	1945	8,134	589	21,280	—	42,110		912,571
	1946	13,803	994	36,912	—	70,239		1,279,743
	1947	11,699	776	29,647	—	53,766		1,101,970
	1948	9,780	706	25,006	—	56,435		995,724
	1949	7,826	543	20,366	—	52,526		860,960
	1950	5,979	433	17,007	—	55,068		780,451
						Requiring Treatment	Not Requiring Treatment	
	1951	4,506	437	14,975	10,794	11,607	26,956	677,251
	1952	3,760	389	15,510	11,552	12,578	25,928	650,014
	1953	3,272	347	15,242	13,157	13,566	25,619	622,368
	1954	2,929	301	13,962	13,279	13,071	24,651	587,805
	1955	2,711	285	14,079	14,269	13,613	24,436	564,283
Females	1939	4,605	11	6,489	—	14,684		723,455
	1940	4,226	21	5,882	—	12,881		597,321
	1941	4,972	20	7,314	—	15,068		593,223
	1942	6,542	27	8,413	—	20,190		704,076
	1943	7,960	32	10,043	—	34,681		868,097
	1944	8,251	28	10,646	—	38,566		916,116
	1945	8,508	29	11,603	—	41,524		911,974
	1946	10,075	34	10,431	—	35,475		864,682
	1947	8,438	27	7,019	—	29,314		721,017
	1948	7,349	21	5,306	—	27,462		663,503
	1949	5,873	19	4,121	—	24,801		585,555
	1950	4,988	17	3,497	—	23,840		529,825
						Requiring Treatment	Not Requiring Treatment	
	1951	3,926	16	3,089	—	8,517	12,408	467,412
	1952	3,362	14	3,585	—	8,916	11,560	427,977
	1953	2,914	9	4,021	—	9,834	10,612	398,902
	1954	2,352	8	3,574	—	10,117	9,503	364,899
	1955	2,272	10	3,766	—	10,182	9,075	340,250

\* Excludes cases transferred from centre to centre.

† Including non-gonococcal urethritis up to 1950.

TABLE B

CASES OF ACQUIRED SYPHILIS IN TABLE A, WITH INFECTIONS OF LESS THAN ONE YEAR

Year	Number		Per cent. of Table A Cases	
	Males	Females	Males	Females
1931	6,421	2,683	56.9	39.3
1932	6,196	2,532	56.2	39.2
1933	5,949	2,141	55.4	35.5
1934	4,888	2,030	50.8	34.8
1935	4,226	1,745	49.2	31.4
1936	4,033	1,642	49.0	32.0
1937	3,986	1,647	49.4	31.9
1938	3,744	1,494	47.8	30.0
1939	3,574	1,412	49.1	30.7
1940	4,029	1,582	56.8	37.4
1941	5,023	2,309	64.5	46.4
1942	5,470	3,576	64.1	54.7
1943	5,159	4,483	58.7	56.3
1944	4,384	4,934	57.2	59.8
1945	5,214	5,527	64.1	64.9
1946	10,705	6,970	77.6	69.2
1947	8,750	5,416	74.8	64.2
1948	6,603	4,034	67.5	54.9
1949	4,392	2,420	56.1	41.2
1950	2,678	1,465	44.8	29.4
1951	1,498	774	33.2	19.7
1952	891	462	23.7	13.7
1953	755	319	23.0	10.9
1954	600	208	20.5	8.9
1955	609	228	22.5	10.0

TABLE C

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES

Year	Under 1 Year	1 and under 5 Years	5 and under 15 Years	15 Years and Over	Totals
1931	339	204	974	922	2,439
1932	302	180	857	805	2,144
1933	305	157	774	780	2,016
1934	296	165	708	839	2,008
1935	251	165	671	944	2,031
1936	241	132	600	935	1,908
1937	211	144	534	940	1,829
1938	216	123	448	951	1,738
1939	217	125	406	866	1,614
1940	191	101	357	709	1,358
1941	223	90	321	746	1,380
1942	245	122	309	788	1,464
1943	310	129	348	940	1,727
1944	346	113	271	822	1,552
1945	326	83	210	736	1,355
1946	363	103	215	701	1,382
1947	343	120	214	676	1,353
1948	372	142	215	678	1,407
1949	355	118	197	747	1,417
1950	227	141	203	652	1,223
1951	156	89	198	684	1,127
1952	110	101	191	547	949
1953	95	77	152	520	844
1954	48	41	119	478	686
1955	41	30	114	459	644

TABLE D

DEATH RATES PER 1,000 LIVE BIRTHS, OF INFANTS UNDER 1 YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS

Year	Rate	Year	Rate	Year	Rate	Year	Rate
1912	1.34	1924	0.91	1936	0.24	1948	0.09
1913	1.46	1925	0.82	1937	0.19	1949	0.08
1914	1.55	1926	0.84	1938	0.18	1950*	0.04
1915	1.44	1927	0.77	1939	0.17	1951*	0.03
1916	1.57	1928	0.71	1940	0.16	1952*	0.03
1917	2.03	1929	0.64	1941	0.21	1953*	0.01
1918	1.90	1930	0.55	1942	0.19	1954*	Nil
1919	1.76	1931	0.45	1943	0.23	1955*	Nil
1920	1.51	1932	0.42	1944	0.16		
1921	1.43	1933	0.35	1945	0.15		
1922	1.12	1934	0.30	1946	0.15		
1923	1.05	1935	0.26	1947	0.09		

Rates for years 1931-1949 are according to the 1940 classification (5th Revision). For 1912-1930 the rates need to be multiplied by the conversion ratio 0.857 for approximate comparability.

\* For 1950-1955, No. 020.2 in International List (6th Revision).

TABLE E

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS, AND ANEURYSM OF THE AORTA

Year	General Paralysis of the Insane		Tabes Dorsalis		Aneurysm of Aorta*	
	Males	Females	Males	Females	Males	Females
1911-20	1,697	383	592	106	838	208
1921-30	1,204	277	631	127	860	249
1931-35	819	240	566	125	969	393
1936-39	625	227	471	106	1,017	531
1940-44	482	167	270	71	467	158
1945-49	258	101	157	41	485	166
1950	111	56	99	24	430	225
1951	121	47	111	32	475	204
1952	78	45	100	27	435	222
1953	91	26	87	26	408	190
1954	89	37	70	26	392	211
1955	84	36	53	24	424	219

The averages for the years 1911 to 1939 are based on the 4th Revision of the International List. Figures for the years 1940 to 1955 are according to the 6th Revision.

Non-civilian deaths are excluded from the table from September 3, 1939, until 1949 for males, and from June 1, 1941, until 1949 for females.

\* For years 1911 to 1939:—

"Aneurysm" (code 96) of the 4th Revision List, based on arbitrary rules of assignment.

For years 1940 and after:—

"Aneurysm of Aorta" (code 022) of the 6th Revision List, based on assignment by the certifying medical practitioner. Aortic Aneurysm specified as "non-syphilitic" or "dissecting" is no longer included in this heading.